Hearts for ALS Grant Form

Individual Information

Name:_____Diagnosis:_____
Address:_____
City:_____ State: _____Zip: _____
E-mail:_____
Contact person _____Phone#_____
Physician_____Phone#_____

Signature:_____
With your signature, you authorize your physician to disclose medical information to Hearts for ALS limited to confirmation of diagnosis in order to fulfill your grant

Please provide any pertinent information about the request _____

_____

_____

☐ **Item/Service Requested**

Describe the requested equipment or service_____

_____

Total cost of equipment/service requested……..$_____
Amount being provided by insurance*……..$_____
Amount being provided by other funding sources*……$_____
Amount that the family is able to pay……$_____
Amount being sought from "Hearts for ALS"…….. $ ☐
Other funding sources that you have approached for assistance (including private insurance, state vocational rehabilitation programs, state technology centers, Medi-cal, Medi-care, etc.)

☐ **Request to attend Loma Linda's Multidisciplinary Clinic**

Hearts for ALS will fund a visit to the multidisciplinary clinic when insurance will not cover the visit.

•All requests are subject to availability of funds and entries shall be picked at the full discretion of "Hearts for ALS". All awards will be paid directly to vendor or Loma Linda University Neurology

Vendor Information

Company:_____Contact:_____
Address:_____
City:_____ State:_____ Zip:_____
E-Mail:_____

Mail Request to: Hearts for ALS, 536 S.Plymouth Pl., Anaheim, Ca. 92806